STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155241	B. WING		10/15/2014
NAME OF D	PROVIDER OR SUPPLIE	R	STREET .	ADDRESS, CITY, STATE, ZIP CODE	
		N.		THOMPSON RD	
FOREST	CREEK VILLAGE		INDIAN	IAPOLIS, IN 46227	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000000					
This visit was for a Recertification and		F000000	Forest Creek Village respectfu	ıllv	
	State Licensure Survey.		1 000000	requests a face to face IDR fo	-
	State Licensule	ourvey.		scope and severity of F223,	
	This visit was in	a conjunction with the		F225, and F226	
	This visit was in conjunction with the Investigation of Complaints IN00157252 and IN00157308.				
	ang mouto/308	0.			
	Curvoy datas: C	October 6 7 8 0 10 12			
	14, and 15, 2014	October 6, 7, 8, 9, 10, 13,			
	14, and 13, 2012	+			
	Facility number	. 000145			
	Provider number				
	AIM number: 1	002/5110			
	Survey team:				
	Dorothy Plumm	er RN_TC			
		RN (October 6, 7, 8, 13,			
	14, and 15, 2014				
		RN (October 6, 7, 8, and			
	9, 2014)	in (October 0, 7, 0, and			
	, ,	(October 7, 8, 9, 10, 13,			
	14, and 15, 2014				
	17, and 13, 2014	T)			
	Census bed type	.			
	SNF: 11	··			
	SNF/NF: 104				
	Total: 115				
	101.113				
	Census payor ty	ne.			
	Medicare: 17	pc.			
	Medicaid: 77				
	Other: 21				
	Ouici. 21				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155241		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 10/15/2014
	PROVIDER OR SUPPLIER CREEK VILLAGE	STREET A 525 E 7	ADDRESS, CITY, STATE, ZIP CODE FHOMPSON RD IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
F000279 SS=D	Total: 115 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 21, 2014; by Kimberly Perigo, RN. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10,			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155241 10/15/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 525 E THOMPSON RD FOREST CREEK VILLAGE INDIANAPOLIS. IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE including the right to refuse treatment under §483.10(b)(4). F000279 **F279 DEVELOP** 11/03/2014 Based on record review and interview, **COMPREHENSIVE CARE** the facility failed to ensure care plans **PLANS** were developed for a resident with A facility must use the results of diabetes (Resident #130) and a resident the assessment todevelop, review with a feeding tube (Resident #38) for 2 and revise the resident's comprehensive plan of care of 28 residents who met the criteria for Whatcorrective action(s) will be review of care plans. accomplished for those residents found to havebeen Findings include: affected by the deficient practice? ·Resident #130 has a care plan 1. The clinical record of Resident #130 fordiabetes was reviewed on 10/8/14 at 2:49 p.m. Diagnoses for the resident included, but ·Resident #38 has a care plan were not limited to diabetes mellitus and for afeeding tube dementia. Diabetes mellitus is a disease Howwill you identify other in which the body is unable to control the residents having the potential amount of sugar in the blood, because it to be affected by thesame does not have enough insulin. deficient practice and what corrective action will be taken? Resident #130 had a physician's order ·All residents who have the diagnosis ofdiabetes, or have a dated 8/8/14, for Lantus insulin to be feeding tube that reside in this injected daily at bedtime. He was also to facility have thepotential to be receive fingerstick blood glucose tests 2 affected by the alleged deficient practice times per day, (ordered 9/5/14) and he was to receive a sliding scale dose of The MDS Coordinator/designee Novolog insulin 2 times per day, based reviewed all clinical records to on the results of his fingerstick glucose identify residentswho have the diagnosis of diabetes or have a tests (ordered 9/5/14). feeding tube and care plan will bedeveloped No care plan for diabetes, including the administration of the fingerstick blood

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glucose tests and administration of

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·TheInterdisciplinary Team will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIC	00	COMPL	ETED
		155241	A. BUIL B. WING			10/15/	2014
			b. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			THOMPSON RD		
EODEST	CREEK VILLAGE				IAPOLIS, IN 46227		
FUREST	CREEK VILLAGE			INDIAN	IAPOLIS, IN 46221		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	insulin, was four	nd in Resident #130's			review all physician's orders,		
	record.				facility activity report,new	_	
					admissions and re-admissions	S,	
	On 10/14/14 at 1	10:40 a.m., the Minimum			and residents with significant changes in theclinical meeting	,	
		Coordinator indicated a			utilizing the IDT	j	
	` '				admission/readmission review	,	
	*	n had not been initiated			form, and IDTQuarterly Resid		
	for Resident #13	30.			Review Form Tool to identify		
					residents who have the		
	2. The clinical r	record of Resident #38			diagnosisof diabetes, or have	а	
	was reviewed or	n 10/15/14 at 9:41 a.m.			feeding tube to ensure		
	Diagnoses for th	e resident included, but			appropriate care plan is		
		to, gastroesophageal			developed dailyMonday-Frida	У	
					and Weekend		
	· ·	ipolar disorder, and			Supervisor/designee will revieus on Saturday and Sunday	ew	
	schizoaffective	disorder.			on Saturday and Sunday		
					·Licensednurses have been		
	Resident #38 ha	d a gastrostomy (enteral)			in-serviced by 11/03/14 by the		
	tube through wh	ich she received all of			Director of Nursing Services		
	her medications.	A gastrostomy tube is a			ordesignee on admission and		
		nserted through the skin			temporary care plans		
		through which feedings					
		, ,			Whatmeasures will be put in	to	
	and medications	can be given.			place or what systemic		
					changes you will make		
	A careplan for c	are of the gastrostomy			toensure that the deficient		
	tube was not fou	and in the Resident #38's			Practice does not recur? All residents who have the		
	record. On 10/1	5/14 at 10:00 a.m., the			diagnosis ofdiabetes, or have	a	
	MDS coordinate	or indicated the resident			feeding tube that reside in this		
	should have a ca				facility have thepotential to be		
		e. A new care plan for			affected by the alleged deficie		
		-			practice		
		ostomy tube was					
	1 1	MDS coordinator on			·The MDS		
	10/15/14 at 10:2	7 a.m.			Coordinator/designee reviewe	edall	
					clinical records to identify	:-	
	3.1-35(a)				residents who have the diagnoral of diabetesor have a feeding to		
					_		
					and care plan will be developed		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155241		A. BUILDING 00		COMPLETED	
		155241	B. WING		10/15/2014
	ROVIDER OR SUPPLIER		525 E T	ADDRESS, CITY, STATE, ZIP CODE FHOMPSON RD IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	RECOLLITION ON	LOC IDEATH THAT INI ONIVATION)		The Interdisciplinary Tean review allphysician's orders, facility activity report, new admissions and re-admissions, and residents significant changes in the climeeting utilizing theIDT admission/readmission reviet form, and IDT Quarterly Res Review FormTool to identify residents who have the diag ofdiabetes, or have a feeding tube to ensure appropriate or plan isdeveloped daily Monday-Friday and Weeken Supervisor/designee will revonSaturday and Sunday Licensednurses have bee in-serviced by 11/03/14 by the Director of Nursing Services ordesignee on admission and temporary care plans Howthe corrective action(see monitored to ensure the deficient practicewill not refice, what quality assurance program will be put into plantation of the CQI committeefor follows. If 95% threshold is notachieved, an action plantation dedication of the developed.	with nical www.ident nosis gare diew nnee d) will ccur, cace? ool onthly for itted ow
F000282	483.20(k)(3)(ii)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 155241 10/15/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 525 E THOMPSON RD FOREST CREEK VILLAGE INDIANAPOLIS. IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG SS=E SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. F 282 SERVICES BY F000282 11/03/2014 QUALIFIEDPERSONS/PER Based on record review and interview, **CARE PLAN** the facility failed to ensure plans of care The servicesprovided or arranged were followed for 2 residents receiving by the facility must be provided by sliding scale insulin (Resident #30 and qualified person inaccordance with each resident's written plan Resident #130) and 2 residents receiving of care. showers (Resident #6 and Resident #41) What corrective action(s) will for 4 of 28 residents reviewed for care be accomplished for those plans being followed. residents found to have been affected by the deficient practice? Findings include: ·Resident #30 will have blood glucosetesting, and sliding scale 1. The clinical record of Resident #130 insulin administered per was reviewed on 10/8/14 at 2:49 p.m. physician's order Diagnoses for the resident included, but ·Resident#130 will have blood were not limited to diabetes mellitus and glucose testing, sliding scale dementia. Diabetes mellitus is a disease insulin administered. in which the body is unable to control the andphysician notification per physician's order amount of sugar in the blood because it does not have enough insulin. ·Resident #6 is receiving A physician's order, dated 9/5/14, showers and shaving per resident preference indicated Resident #130 was to receive fingerstick blood sugar tests 4 times per ·Resident #41 is receiving day for 1 week, then 2 times per day showers pershower schedule thereafter. The order indicated he was to receive Novolog sliding scale insulin (a How will you identify other medication injected into the body to help residents havingthe potential lower blood sugar) according to the to be affected by the same

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STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155241 10/15/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 525 E THOMPSON RD FOREST CREEK VILLAGE INDIANAPOLIS. IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG deficient practice and what following sliding scale: correctiveaction will be taken? ·All residents who have blood Blood sugar (BS) results: 1-150 = 0 units glucose testing, receive sliding of Novolog insulin scale insulin, receive assistance BS 151-200 = 2 units insulin with bathing and shaving have the potential to be affected by the BS 201-250 = 4 units insulin alleged deficient practice BS 251-300 = 6 units insulin BS 301-350 = 8 units insulin ·All resident that require BS 351-400 = 10 units insulin assistance with bathing or shaving will be interviewed by BS 401-450 = 12 units insulin Customer Care Reps on bathing Call physician if BS less than 60 or over and shaving preferences and 350. care plan will be updated ·Licensed nurses have been A Diabetic Monitoring Flowsheet for in-serviced by Director of Nursing September, 2014 indicated the following: Services or designee by 11/03/14 on blood glucose monitoring, On 9/12/14 at 11:00 a.m. Resident #130's medication administration including administration of sliding blood sugar was 353. There was no scale insulin per physician's indication in the record the physician was orders and physician notification notified, according to orders. of blood sugars outside of the call parameters 9/18/14 at 6:00 a.m. BS = 223. 2 units of ·Licensed Nurses will have insulin given. Should have received 4 another Licensed Nurse verify units. that the correct dose of sliding 9/19/14 at 4:00 p.m. BS = 180. No scale insulin is drawn up before insulin was indicated as given. Should administration and cosign the Blood Glucose Monitoring Tool have received 2 units. 9/20/14 at 4:00 p.m. BS = 164. No ·Licensed Nurses and Certified insulin was indicated as given. Should Nurse's Aides have been have received 2 units. in-serviced on bathing and shaving per resident preference, shower sheets, and bathing documentation in Point of Care by the Director of Nursing Services/designee by 11/3/14

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLET	ΓED
		155241	A. BUII			10/15/2	014
			B. WIN		ADDRESS CITY STATE TIP CODE		-
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
FODEOT					THOMPSON RD		
FOREST	CREEK VILLAGE			INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2. The clinical re	ecord review completed					
	10/14/14 at 11:4	3 a.m., indicated			·Blood Glucose Monitoring		
	Resident #30 ha	d diagnoses including,			audits will be completed daily		
	but not limited to	•			reviewed by Director of Nursin	•	
		o, diabetes.			Service/ designee to ensure to blood glucose monitoring, slid		
	TEL 1.1.1	6.1			scale insulin, physician	"' ¹⁹	
	-	on of physician's orders			notification are done per		
		31/14, included an order			physician orders daily		
		of 8/27/14, for the			Monday-Friday and Weekend		
	resident to have	blood glucose testing and			Supervisor/designee on Satur	day	
	Humalog (a short acting type of insulin)				and Sunday		
	administered on	a sliding scale dosage 3					
	times a day.				·The Interdisciplinary Team	WIII	
	diffics a day.				review all physicians orders related to blood glucose in clir	nical	
	A	C 1 - 1 - 1 0 / 20 / 1 4			meeting to ensure that service		
		f care dated 8/29/14,			are provided according to		
		ident was at risk for			physician's orders.		
		of hyperglycemia (high					
	blood sugar) or l	hypoglycemia (low blood			·The Interdisciplinary Team	will	
	sugar) related to	the diagnosis of			review in clinical meeting all		
	diabetes. Interv	entions included, but			shower sheets against the	.	
		to, monitor blood sugars			shower schedule Monday-Frid	aay	
	as ordered.	to, memor ereca sagars			and weekend supervisor/designee on Satur	day	
	as ordered.				and Sunday to ensure shower	-	
		G 31 DI 1 GI			were offered and appropriate		
		Capillary Blood Glucose			documentation occurred		
	_	I for September 2014,					
	lacked documen	tation of glucose testing					
	and sliding scale	e insulin administration					
	on 9/21/14 at 11	:00 a.m., on 9/29/14 at					
		/30/14 at 6:00 a.m.			What measures will be put in	I	
	,				place or whatsystemic change	_	
	During an inters	riew with Unit Manager			you will make to ensure that		
	_	· ·			the deficient practice does notrecur?		
	(UM) #6 on 10/14/14 3:30 p.m., UM #6				·All residents who have bloo	,d	
	indicated the staff records the blood				glucose testing, receive sliding		
	sugars on the flo	owsheet when completed.			scale insulin, receive assistan	-	
					with bathing and shaving have		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155241 10/15/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 525 E THOMPSON RD FOREST CREEK VILLAGE INDIANAPOLIS. IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG potential to be affected by the During an interview with the Director of alleged deficient practice Nursing Services (DNS) and the Corporate Nurse Consultant on 10/15/14 ·All resident that require at 3:30 p.m., the DNS indicated blood assistance with bathing or glucose monitoring and the shaving will be interviewed by Customer Care Rep on bathing administration of sliding scale insulin and shaving preferences and should be recorded on the Capillary care plan will be updated Blood Glucose Monitoring Tool. ·Licensed nurses have been in-serviced by Director of Nursing 3. During a Stage 1 interview on 10/7/14 Services or designee by 11/03/14 at 9:59 a.m., Resident #6 was observed on blood glucose monitoring, with unshaven facial hair. Resident #6 medication administration including administration of sliding indicated shaving was provided on scale insulin per physician's showers days, he received 1 shower a orders and physician notification week, and the last shower was completed of blood sugars outside of the call last week. The resident expressed a parameters preference for more frequent shaving and ·Licensed Nurses will have bathing. another Licensed Nurse verify that the correct dose of sliding The clinical record review on 10/8/14 at scale insulin is drawn up before 2:36 p.m., indicated Resident #6 had administration and cosign the Blood Glucose Monitoring Tool diagnoses including, but not limited to, cerebral vascular accident (CVA/stroke) ·Licensed Nurses and Certified with right sided hemiparesis (weakness Nurse's Aides have been of the entire right side). in-serviced on bathing and shaving per resident preference, shower sheets, and bathing An annual Minimum Data Set assessment documentation in Point of Care by (MDS) completed 7/22/14, assessed the Director of Nursing Resident #6 with a Brief Interview for Services/designee by 11/3/14 Mental Status (BIMS) of 10 out of 15, ·Blood Glucose Monitoring Tool indicating moderate cognitive audits will be completed daily and impairment. The resident was assessed reviewed by Director of Nursing as requiring extensive assistance of 2 plus Service/ designee to ensure that staff members for bed mobility, transfers, blood glucose monitoring, sliding

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIVI	DING	00	COMPLI	ETED
		155241	A. BUII			10/15/2	2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
FOREST	CDEEK VIII I ACE				HOMPSON RD		
FUREST	CREEK VILLAGE			INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	toileting, and per	rsonal hygiene. No			scale insulin, physician		
	behaviors, include	ding rejection of care,			notification are done per		
	were coded for the resident.				physician orders daily		
	Were coded for t	ne resident.			Monday-Friday and Weekend	dov	
	Ai441	form for Donidant 46			Supervisor/designee on Satur and Sunday	uay	
	-	f care for Resident #6			and Guilday		
	· · · · · · · · · · · · · · · · · · ·	, indicated the resident			·The Interdisciplinary Team	will	
		eficit related to the			review all physicians orders		
	inability to indep	pendently perform ADL's			related to blood glucose in clir	nical	
	with the diagnos	is of CVA and right			meeting to ensure that service	s	
	sided hemipares	is. Interventions			are provided according to		
	_	re not limited to, the			physician's orders.		
	· · · · · · · · · · · · · · · · · · ·	e provided a shower 2			The Interdicciplinary Team	will	
		d a partial bath in			The Interdisciplinary Team review in clinical meeting all	WIII	
		-			shower sheets against the		
		wers. The plan of care			shower schedule Monday-Fric	lav	
	did not include a	shaving preference.			and weekend		
					supervisor/designee on Sature	day	
	During an interv	iew with Unit Manager			and Sunday to ensure shower	s	
	(UM) #3 on 10/8	3/14 at 11:30 a.m., the			were offered and appropriate		
	UM #3 provided	shower sheets for			documentation occurred		
	_	September and October					
		ted the staff also			How the corrective action(s) will be monitoredto ensure to		
	•				deficient practice will not rec		
		provision of care in the			i.e., what quality	,ui,	
		utilized by the facility.			assuranceprogram will be pu	ıt	
		I shaving was provided			into place?	"	
	on shower days,	and if a resident			·Blood Glucose Testing and		
	requested more f	frequent shaving then the			Accommodation of Needs		
	profile for the re	sident was updated to			CQItool will be utilized weekly	x 4,	
	•	st. UM #3 indicated the			monthly x 6,and quarterly		
	•	was utilized as an			thereafter for one year. Data v	vill	
	-	t for the certified nursing			be submitted to the CQI	,	
		•			committee for follow up. If 95° threshold is not achieved, an	70	
	,	s). Reviewed resident			actionplan will be developed.		
	•	#3 and no shaving			action plan will be acveloped.		
	preference was i	ndicated on the profile.					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 10/15/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 E THOMPSON RD INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		shower sheets indicated ived a shower 9/23, 9/30,						
	Nursing Services of the shower sets schedule was the utilized on the E #6 resided. The indicated Reside received shower Fridays during the On 10/9/14 at 11 Coordinator proof from the comput of Care History'' documentation of baths for 9/1/14 report lacked do provision of a sh through 10/9/14 4. During a Stag Resident #41 on resident was obsyellow matting it orange colored s	49 p.m., the Director of s (DNS) provided a copy hedule and indicated the current schedule ast Unit where Resident shower schedule in #6 should have son Tuesdays and he evening shifts. :20 a.m., the MDS wided a report generated for system titled, "Point which included of showers and partial through 10/9/14. The cumentation of the allower from 9/23/14 for Resident #30. e 1 interview with 10/6/14 at 3:28 p.m., the erved to have a thick in both eyes and an ubstance around the the chin in white facial						
		ord review completed on o.m., indicated Resident						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155241	B. WING	·		10/15/	2014
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
					HOMPSON RD		
	CREEK VILLAGE		<u> </u>		APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION
TAG		,		TAG	BEIGENCI		DATE
		es including, but not					
		cerebral vascular					
		stroke) with left sided					
	_	akness of the entire left					
	side).						
	A	innum Data Cat					
	A quarterly Min						
	`	S) completed 9/27/14,					
		nt #41 as having a Brief					
		ental Status (BIMS) of 5					
	·	ating moderate cognitive					
	_	e resident was assessed					
		ensive assistance of 2 plus					
		bed mobility, transfers,					
	•	g, and personal hygiene.					
		indicated the resident					
		or not directed toward					
	_	ion of care 1-3 days of					
	the assessment p	eriod.					
	1	C C D 11 (1141					
		f care for Resident #41					
		/2011, indicated the					
		If care deficit related to					
	1	ndependently perform					
	· ·	y living (ADL's) with a					
	"	A with left sided					
	-	erventions included, but					
		to, dependent of 2 staff					
		ded, provide oral care at					
	_	day, and provide shower					
	_	with partial bath in					
	between and pre						
	Wednesday/Satu	ırday.					

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Event ID:

ZKCR11 Facility ID: 000145

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPL 10/15/	ETED
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE HOMPSON RD		
	CREEK VILLAGE			INDIAN	APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	(UM) #3 on 10/8 UM #3 provided Resident #41 for 2014, and indica documented the computer system On 10/8/14 at 2:A Nursing Services of the shower sels schedule was the utilized on the Ea #41 resided. The indicated Reside received showers Fridays during th During an interv a.m., UM #3 ind frequently refuse removing substat and showers and multiple attempts A review of the se the resident receive 9/16, and 9/23/14 9/25, 10/3, and 1 refusing a shower was provided for the dates 9/2, 9/1	provision of care in the autilized by the facility. 49 p.m., the Director of (DNS) provided a copy hedule and indicated the ecurrent schedule ast Unit, where Resident eshower schedule nt #41 should have son Tuesdays and he evening shifts. iew 10/9/14 at 10:30 hicated the resident ed care including have from the facial hair staff had to make so to complete care. Shower sheets indicated hived a showers 9/5, 9/12, 4 and a bed bath 9/9, 0/7/14 due to resident er. No documentation a shower or bed bath for					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE (COMPL		
		155241	B. WIN			10/15/	2014
NAME OF P	ROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE	•	
FOREST	CREEK VILLAGE				HOMPSON RD APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Coordinator provision the comput of Care History" documentation of baths for 9/1/14 report lacked documentation of a ship through 10/9/14, During an intervation of 10/10/14 at 4:30 the shower sheet used by the staff provision of show be documenting when a shower with the control of 10/8/14 at 2:10 Nursing Services undated policy of and indicated it was downwell of the control o	rided a report generated er system titled, "Point which included f showers and partial through 10/9/14. The cumentation of the ower from 9/17/14 for Resident #41. iew with the DNS on p.m., the DNS indicated s were an internal tool to document the wers and the staff should in the computer system					
F000312	483.25(a)(3)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155241	A. BUII B. WIN	LDING		10/15/	2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
FOREST	CREEK VILLAGE				THOMPSON RD		
FUREST	CREEK VILLAGE			INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=D		IDED FOR DEPENDENT					
	RESIDENTS						
		unable to carry out					
	activities of daily linecessary services						
		g, and personal and oral					
	hygiene.	g, and personal and oral					
		ation, interview, and	F00	0312	F312 ADL care		11/03/2014
	· · · · · · · · · · · · · · · · · · ·	e facility failed to			provided		
	provide the neces	ssary services to			•		
	maintain good gr	cooming and personal			fordependent		
	hygiene for 2 of	3 residents reviewed for			residents		
	Activities of Dai	ly Living (ADL's).			A resident who is unableto)	
	(Resident #30 an	d Resident #41)			carry our activities of daily	y	
					living receives the necessar	ry	
	Findings include	:			services tomaintain good		
					nutrition, grooming, and		
	1. During a Stage	e 1 interview on 10/7/14			personal and oral hygiene.		
		ident #30 was observed					
	with unshaven fa	icial hair. Resident #30			What corrective action(s) will	I	
	indicated shaving	g was provided on			be accomplishedfor those		
	_	received 1 shower a			residents found to have beer	1	
		st shower was completed			affected by the deficient practice?		
		esident expressed a			Resident #30was incorrectly	.,	
		•			identified in 2567. Should be	y	
	_	ore frequent shaving and			Resident #6. Resident#6 is		
	bathing.				receiving showers and shaving	9	
					per resident preference		
	The clinical reco	rd review on 10/8/14 at					
	2:36 p.m., indica	ted Resident #30 had			Resident #41 is receiving		
		ing, but not limited to,			showers pershower schedule		
		accident (CVA/stroke)			How will you identify other		
		nemiparesis (weakness			How will you identify other residents havingthe potentia	ı	
	of the entire righ	-			to be affected by the same	•	
	of the chine fight	i side j.			deficient practice and what		
	13.5	D + C +			correctiveaction will be taker	1?	
	An annual Minin	num Data Set assessment			·All residents who receive		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155241	A. BUII B. WIN			10/15/2014
		1	D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R			THOMPSON RD	
	CREEK VILLAGE				IAPOLIS, IN 46227	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ed 7/22/14, assessed			assistance with bathing and shaving have the potential to	ho
	Resident #30 wi	ith a Brief Interview for			affected by the alleged deficie	
	Mental Status (I	BIMS) of 10 out of 15,			practice	
	indicating mode	erate cognitive			<u> </u>	
	impairment. Th	ne resident was assessed			·All resident that require	
	as requiring exte	ensive assistance of 2 plus			assistance with bathing or	
	1 1	or bed mobility, transfers,			shaving will be interviewed by	
		ersonal hygiene. No			Customer Care Reps on bath and shaving preferences and	ing
		ding rejection of care,			care plan will be updated	
	were coded for	C 3			and plan will be apacted	
	were coded for	the resident.			·Licensed Nurses and Certi	fied
		C C D :1 4//20			Nurse's Aides have been	
		of care for Resident #30			in-serviced on bathing and	
		, indicated the resident			shaving per resident preferen	ce,
		leficit related to the			shower sheets, and bathing documentation in Point of Car	ro hy
	inability to inde	pendently perform ADL's			the Director of Nursing	le by
	with the diagnos	sis of CVA and right			Services/designee by 11/3/14	
	sided hemipares	sis. Interventions				
	included, but we	ere not limited to, the			·Director of Nursing Service	e/
	· ·	be provided a shower 2			designee will review shower	
		d a partial bath in			sheets against the shower	
		owers. The plan of care			schedule Monday-Friday and weekend supervisor/designed	•
		a shaving preference.			Saturday and Sunday to ensu	
	ara not include	a snaving preference.			showers were offered and	
	D. since 1.4	i. M. Ti. bas			appropriate documentation	
		view with Unit Manager			occurred per resident prefere	nce
	` ′	8/14 at 11:30 a.m., the				
	_	d shower sheets for			·Licensed Nurses will condu	uct
	Resident #30 fo	r September and October			rounds on all shifts to ensure	lean
	2014, and indica	ated the staff also			residents well groomed and c	icall
	documented the	provision of care in the				
		n utilized by the facility.			What measures will be put in	nto
		d shaving was provided			place or whatsystemic chan	
		, and if a resident			you will make to ensure that	_
	_	frequent shaving then the			the deficient practice does	
	_				notrecur?	
	profile for the re	esident was updated to			·All residents and new resid	lents

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	TED
		155241	A. BUII B. WIN			10/15/2	2014
		<u> </u>	D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIE	R			THOMPSON RD		
FOREST	CREEK VILLAGE				JAPOLIS, IN 46227		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	est. UM #3 indicated the			that require assistance with		
	resident profile	was utilized as an			bathing or shaving will be interviewed by Customer Car	_	
	assignment shee	et for the certified nursing			Rep on bathing and shaving	~	
	assistants (CNA	s). Reviewed resident			preferences and care plan wi	ll be	
	profile with UM	f #3 and no shaving			updated		
	_	indicated on the profile.					
	A review of the shower sheets indicated the resident received a shower 9/23, 9/30, and 10/7/14. On 10/8/14 at 2:49 p.m., the Director of				·Licensed Nurses and Certi	fied	
					Nurse's Aides have been		
					in-serviced on bathing and shaving per resident preferen		
					shower sheets, and bathing	, lo c ,	
					documentation in Point of Ca	re by	
					the Director of Nursing	- /	
					Services/designee by 11/3/14	.	
	Nursing Service	es (DNS) provided a copy					
	of the shower so	chedule and indicated the			·Director of Nursing Service	e/	
	schedule was th	e current schedule			designeewill review shower		
	utilized on the F	East Unit where Resident			sheets against the shower schedule Monday-Friday and		
		ne shower schedule			weekendsupervisor/designee		
		ent #30 should have			Saturday and Sunday to ensu		
					showers were offered		
		rs on Tuesdays and			andappropriate documentation		
	Fridays during t	the evening shifts.			occurred per resident prefere		
					·Licensed Nurses will condu	uct	
		1:20 a.m., the MDS			rounds on all shifts to ensure	lean	
	Coordinator pro	ovided a report generated			residents well groomed and c	icaii	
	from the compu	ter system titled, "Point					
	of Care History	" which included			How the corrective action (s	s)	
	documentation	of showers and partial			will bemonitored to ensure t		
		through 10/9/14. The			deficient practice will not re	cur,	
		ocumentation of the			i.e., what qualityassurance	_	
		hower from 9/23/14			program will be put into place		
	_	, for Resident #30.			·Accommodation of Needs	I	
	uiiougii 10/9/14	e, 101 Nestuelli #30.			tool will be utilizedweekly x 4, monthly x 6, and quarterly		
	2.5	4 - 7			thereafter for one year. Data	will	
		ge 1 interview with			be submitted to the CQI		
		10/6/14 at 3:28 p.m., the			committeefor follow up. If 95	%	
	resident was ob	served to have a thick			threshold is notachieved, an		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155241		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 10/15/	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE HOMPSON RD APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	orange colored s	n both eyes and an ubstance around the the chin in white facial			action plan will be developed.		
	10/8/14 at 2:47 p #41 had diagnose limited to, right of accident (CVA/s	ord review completed on o.m., indicated Resident es including, but not cerebral vascular stroke) with left sided akness of the entire left					
	assessed Resider Interview for Me out of 15 indicat impairment. The as requiring exte staff member for dressing, toiletin The assessment in exhibited behavior	S) completed 9/27/14, at #41 as having a Brief ental Status (BIMS) of 5 ing moderate cognitive eresident was assessed ensive assistance of 2 plus bed mobility, transfers, g, and personal hygiene. Indicated the resident or not directed toward ion of care 1-3 days of					
	completed 10/14 resident had a se the inability to in activities of daily diagnosis of CV.	f care for Resident #41 /2011, indicated the If care deficit related to adependently perform y living (ADL's) with a A with left sided erventions included, but					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE COMPL		
THIND I LITTLE	or conduction	155241		LDING		10/15/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	10/10/	
NAME OF I	PROVIDER OR SUPPLIER				HOMPSON RD		
FOREST	CREEK VILLAGE				APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICI I		DATE
		to, dependent of 2 staff					
		ded, provide oral care at					
	least 2 times per day, and provide shower						
	2 times per week with partial bath in between and prefers						
	•						
	Wednesday/Saturday.						
	During an interv	iew with Unit Manager					
	_ ~	3/14 at 11:30 a.m., the					
	` ′	· ·					
UM #3 provided shower sheets for Resident #41 for September and October							
2014, and indicated the staff also							
documented the provision of care in the							
		n utilized by the facility.					
	computer system	i utilized by the facility.					
	On 10/8/14 at 2:	49 p.m., the Director of					
		s (DNS) provided a copy					
		hedule and indicated the					
		e current schedule					
		ast Unit, where Resident					
		e shower schedule					
		nt #41 should have					
		s on Tuesdays and					
		ne evening shifts.					
		U					
	During an interv	iew 10/9/14 at 10:30					
	a.m., UM #3 ind	icated the resident					
	frequently refuse	ed care including					
	removing substa	nces from the facial hair					
	_	staff had to make					
	multiple attempt	s to complete care.					
	, r	•					
	A review of the	shower sheets indicated					
	the resident rece	ived a showers 9/5, 9/12,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	or connection	155241		LDING	00	10/15/	
		100241	B. WIN		PRESIDENCE CONTROL OF CORP.	10/10/	2014
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HOMPSON RD		
FOREST	CREEK VILLAGE				APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	4 and a bed bath 9/9,					
		0/7/14 due to resident					
	_	er. No documentation					
	•	a shower or bed bath for					
	the dates 9/2, 9/19 or 9/30/14.						
		:20 a.m., the MDS					
Coordinator provided a report generated							
		er system titled, "Point					
of Care History" which included							
documentation of showers and partial							
baths for 9/1/14 through 10/9/14. The							
	•	cumentation of the					
	•	ower from 9/17/14					
	through 10/9/14,	for Resident #41.					
	During an interv	iew with the DNS on					
	_	p.m., the DNS indicated					
		s were an internal tool					
	used by the staff						
	_	wers and the staff should					
	•	in the computer system					
	when a shower v						
		p					
	On 10/8/14 at 2::	38 p.m., the Director of					
		s (DNS) provided an					
	undated policy o	n Showers and Oral Care					
		was the current policy					
		ity. The policy indicated,					
	_	a shower to each					
		eekly or per resident					
	preference"						
	•						
	3.1-38(a)(3)(D)						

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AND PLAN OF CORRECTION 15241	NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING STREET AD 525 E TH INDIANAL INDIANAL PREFIX TAG TAG TAG TAG	DDRESS, CITY, STATE, ZIP CODE HOMPSON RD APOLIS, IN 46227 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	10/15/2014 (X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG 3.1-38(b)(2) F000322 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's cilinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure	NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION
SAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE SUMMARY STATEMENT OF DEFICIENCIES MDIANAPOLIS, IN 46227	NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
FOREST CREEK VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) APPROPRIATE (EACH DEFI	FOREST CREEK VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 3.1-38(b)(2) F000322 483.25(g)(2) SS=D NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFY INFORMATION	TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	CROSS-REFERENCED TO THE APPROPRIAT	IE
F000322 SS=D A83.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure			DATE
F000322 SS=D A83.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure	3.1-36(0)(2)		DAIL
an enteral tube according to their policy, for 1 of 1 observation of medications administered through an enteral tube. (Resident #38) Findings include: The clinical record of Resident #38 was reviewed on 10/15/14 at 9:41 a m Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice? Resident #38 has placement of enteraltube verified prior to administration of medications through enteral tubeaccording to American Senior Community	SS=D NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure medications were administered through an enteral tube according to their policy, for 1 of 1 observation of medications administered through an enteral tube. (Resident #38) Findings include: The clinical record of Resident #38 was reviewed on 10/15/14 at 9:41 a.m.	NGTreatment/Services-Restor Eating Skills Whatcorrective action(s) will accomplished for those residents found to havebeen affected by the deficient practice? Resident #38 has placement enteraltube verified prior to administration of medications through enteral tubeaccording	be
	Diagnoses for the resident included, but	policy	

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STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155241 10/15/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 525 E THOMPSON RD FOREST CREEK VILLAGE INDIANAPOLIS. IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG ·LPN#7 was in-serviced were not limited to bipolar disorder and immediately by the Unit Manager schizoaffective disorder. on the EnteralTube-Medication Administration and Enteral Tube A recapitulated physician's order for Procedure policy. October, 2014, with an original order date of 7/7/14, indicated Resident #38 Howwill you identify other was to receive all of her medications residents having the potential through her gastrostomy tube (GT), a to be affected by thesame tube surgically inserted through the skin deficient practice and what into the stomach. A GT is also called an corrective action will be taken? Allresidents receiving enteral tube. medications via g-tube have the potential to be affected On 10/8/14 at 12:10 p.m., Licensed Practical Nurse (LPN) #7 was observed ·LicensedNurses have been in-serviced on verifying G-Tube preparing to give a medication to placement prior to Resident #38 through her enteral tube. medicationadministration by the Unit Manager #6 was also in the room Director of Nursing observing. Services/designee by 11/3/14 ·AllLicensed Nurses will LPN #7 washed her hands, and used a complete an observed G-tube syringe to check for residual. There was skills validation by DNS no residual observed. LPN #7 then ordesignee to verify training appeared to be starting to put Resident ·Directorof Nursing/Designee #38's medication through her enteral will make rounds each shift to tube. Unit Manager #6 stopped her and ensure placement is verified prior asked, "Did you bring your stethoscope to medication administration with you." LPN #7 answered, "No, I forgot it." Unit Manger #6 left the room, Whatmeasures will be put into returned with a stethoscope, and handed place or what systemic it to LPN #7. At that time, LPN #7 changes you will make injected a small amount of air into the toensure that the deficient practice does not recur? enteral tube, while listening to the stomach with the stethoscope. This was ·Licensed Nurses have been done to check correct placement of the in-serviced on verifying G-Tube

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155241	B. WIN			10/15/	2014
			b. Will		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			HOMPSON RD		
FOREST	CREEK VILLAGE				APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	enteral tube. On 10/15/14 at an Nursing Service 9/2012, titled En and indicated it used by the facilitused	1:05 p.m., the Director of s provided a policy, dated nteral Tube Procedure, was the policy currently lity. The policy indicated, abe - Gastric Content & are5. Attach a 30-60 cc ng tube and aspirate for ss7. Remove syringe cc [cubic centimeters]. 8. Place stethoscope on tach syringe to end of why inject 20-30 cc of air tube. Listen to detect a bling or gurgling sound placement and patency" ation Handbook ch Edition indicated, Administration ninistration Via Enteral res:6. Prepare administration. 7. bed 30 to 45 degrees. 8. or tube placement. Check			placement prior to medication administration by the Director Nursing Services/designee by 11/3/14 ·AllLicensed Nurses and all nurses hired will complete an observed G-tubeskills validation by DNS or designee to verify training ·Directorof Nursing/Designee will make rounds each shift date to ensureplacement is verified prior to medication administrate. Howthe corrective action(s) where the deficient practice will not receive, what quality assurance program will be put into place. Enteral Therapy CQI tool where the deficient practice will not receive action the designed will be submitted to the CQI committee for follow up of the program will be developed an action plan will be developed.	of new on e iily iiin x 6, e c p, d,	
	3.1-44(a)(2)						
F000329	483.25(I)						
F000329	483.∠5(I)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	NING	00	COMPL	ETED
		155241	B. WING			10/15/	2014
			D. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HOMPSON RD		
EODEST	CREEK VILLAGE				APOLIS, IN 46227		
FUREST	CREEK VILLAGE			INDIAN	APOLIS, IN 40221		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=D	DRUG REGIMEN						
	UNNECESSARY I						
		ug regimen must be free					
		drugs. An unnecessary					
	drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose						
		d or discontinued; or any					
	combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that						
		e not used antipsychotic					
	•	n these drugs unless					
		therapy is necessary to ndition as diagnosed and					
	•	e clinical record; and					
		antipsychotic drugs					
		ose reductions, and					
		ntions, unless clinically					
		an effort to discontinue					
	these drugs.						
	Based on intervie	ew and record review,	F000	329	F329 DRUG REGIMEN IS FR	EE	11/03/2014
	the facility failed	l to ensure blood glucose			FROM UNNECESSARY DRUG	SS	
	•	sliding scale insulin			Each resident's drug regimen		
	•	ras completed for 1 of 2			must be free fromunnecessary		
		*			drugs. An unnecessary drugis		
		ed for blood glucose			any drug when used in excess	ive	
	monitoring. (Re	sident #30)			dose (including duplicate therapy); or forexcessive		
					duration; or without adequate		
	Findings include	:			monitoring; or without		
	-				adequateindications for its use	; or	
	The clinical reco	ord review completed			in the presence of adverse	-	
	10/14/14 at 11:43	•			consequences whichindicate the	he	
					dose should be reduced or		
		d diagnoses including,			discontinued; or any		
	but not limited to	o, diabetes.			combinations of thereasons		
					above		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		n.c	00	COMPLET	TED
		155241	A. BUILD B. WING	ING		10/15/20	014
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
FODEST	CREEK VILLAGE				HOMPSON RD		
FUREST	CREEK VILLAGE			INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The recapitulation	on of physician's orders			Whatcorrective action(s) will	be	
	for 10/1/14 - 10/	31/14 included an order			accomplished for those		
	with a start date	of 8/27/14, for the			residents found to havebeen		
		blood glucose testing and			affected by the deficient		
					practice?		
		rt acting type of insulin)			Resident #30 will have bloc	I	
		a sliding scale dosage 3			glucosemonitoring and sliding scale insulin administered per		
	times a day.				physician's order		
					Howwill you identify other		
	A written plan of care dated 8/29/14,				residents having the potentia	al	
	indicated the resident was at risk for				to be affected by thesame		
	adverse effects of hyperglycemia (high				deficient practice and what		
	blood sugar) or hypoglycemia (low blood				corrective action will be take	n?	
	sugar) related to the diagnosis of				·All residents who have bloc	od	
	- '	_			glucose testing, receive sliding		
		entions included, but			scale insulin have the potentia	ıl to	
	were not limited	to, monitor blood sugars			be affected by the alleged		
	as ordered.				deficient practice		
					·Licensed nurses have beer		
	A review of the	Capillary Blood Glucose			in-serviced by Director of Nurs	I	
		l for September 2014,			Services or designee by 11/03		
	_	-			on blood glucose monitoring,		
		tation of glucose testing			medication administration		
	_	e insulin administration			including administration of slid	ling	
		:00 a.m., on 9/29/14 at			scale insulin per physician's		
	6:00 a.m., and o	n 9/30/14 at 6:00 a.m.			orders		
	During an interv	view with Unit Manager			·Licensed Nurses will have		
	•	3:30 p.m., UM #6			another Licensed Nurse verify		
		ff records the blood			that the correct dose of sliding scale insulin is drawn up before		
					administration and cosign the		
	sugars on the flo	wsheet when completed.			Blood Glucose Monitoring Too	_{ol}	
	During an interv	view with the Director of			·Blood Glucose Monitoring	ΓοοΙ	
	Nursing Service	s (DNS) and the			audits will be completed daily		
	Corporate Nurse	Consultant on 10/15/14			reviewed by Director of Nursin		
	-	DNS indicated blood			Service/ designee to ensure the	nat	
	_				blood glucose monitoring and		
	glucose monitor	ing and the			sliding scale insulin are done	per	

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	OF CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
I I I DI LINI	o. condenon	155241	A. BUILDING		10/15/2014
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	R		THOMPSON RD	
FOREST	CREEK VILLAGE		INDIAN	IAPOLIS, IN 46227	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE
TAG		f sliding scale insulin	TAG	physician orders daily	DATE
		led on the Capillary		Monday-Friday and Weeken	
	Blood Glucose N			Supervisor/designee on Satu	ırday
				and Sunday	
	3.1-48(a)(3)			·The Interdisciplinary Team	n will
				review all physicians orders related to blood glucose in cl	inical
				meeting to ensure that service	
				are provided according to	
				physician's orders Monday-F and weekend	riday
				supervisor/designee on Satu	rday
				and Sunday	
				Whatmeasures will be put in	nto
				place or what systemic	
				changes you will make toensure that the deficient	
				practice does not recur?	
				·Licensed nurses have bee	
				in-serviced by Director of Null Services or designee by 11/0	
				on blood glucose monitoring,	
				medication administration	
				including administration of sli scale insulin per physician's	ding
				orders	
				Linemand Niversa will be	
				·Licensed Nurses will have another Licensed Nurse verif	
				that the correct dose of slidin	· I
				scale insulin is drawn up before	
				administration and cosign the Blood Glucose Monitoring To	
				_	
				·Blood Glucose Monitoring	
				audits will be completed daily reviewed by Director of Nurs	
				Service/ designee to ensure	that
				blood glucose monitoring and	d

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	OF CORRECTION	IDENTIFICATION NUMBER: 155241	A. BUILDING B. WING	00 	COMPLETED 10/15/2014
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
FOREST	CREEK VILLAGE			FHOMPSON RD IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				sliding scale insulin are done p physician orders daily Monday-Friday and Weekend Supervisor/designee on Sature and Sunday	
				·The Interdisciplinary Team review all physicians orders related to blood glucose in clir meeting to ensure that service are provided according to physician's orders Monday-Fri and weekend supervisor/designee on Saturd and Sunday	day
				Howthe corrective action(s) to be monitored to ensure the deficient practicewill not reci.e., what quality assurance program will be put into place. Blood Glucose Monitoring Cool will be utilizedweekly x 4, monthly x 6, and quarterly thereafter for one year. Data to be submitted to the CQI committeefor follow up. If 95% threshold is notachieved, an action plan will be developed.	ur, e? CQI will
F000333 SS=D	ERRORS The facility must e	E OF SIGNIFICANT MED ensure that residents are cant medication errors.			
	Based on observ interview, the fac	ation, record review, and cility failed to ensure a measured properly to osage for 1 of 28	F000333	F333 What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155241	A. BUIL		<u> </u>	10/15/	′2014
		1	B. WING				
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					THOMPSON RD		
FOREST	CREEK VILLAGE			INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					practice?		
	Findings include	<u>.</u> .			·Resident #38 receives Lithi	um	
					perphysician's order		
	The clinical rese	ord of Resident #38 was					
					·LPN #7 was immediately		
		15/14 at 9:41 a.m.			inserviced byUnit Manager on		
	Diagnoses for th	e resident included, but			Enteral Medication administra		
	were not limited to bipolar disorder and schizoaffective disorder.				including administrationof liqu medications and correct dosa		
					How will you identify other	ge	
					residents havingthe potentia	ıl.	
	A reconitulated	nhygigian's order for			to be affected by the same	•	
		physician's order for			deficient practice and what		
	October, 2014, with an original order				correctiveaction will be take	n?	
	date of 7/7/14, indicated Resident #38				·All residents who receive lie		
	was to receive all of her medications				suspension medications have	•	
	through her gast	rostomy tube (GT), a			potential to be effected by the		
		nserted through the skin			alleged deficient practice		
	into the stomach	•					
	into the stomach				·Licensed Nurses will be		
					in-serviced on Medication		
		physician's order for			Administration including prepa	aring	
	October, 2014, v	with an original order			correct doses of liquid		
	date of 7/3/14, in	ndicated Resident #38			suspensions by 11/3/14		
	was to receive li	thium carbonate 60 mg			·Medication Pass skills		
	(milligrams) per	•			validation to beconducted on		
	1	ml's, to equal 125			Licensed Nurses by Director of	of	
					Nursing or designee	,	
	milligrams, per	GT 3 times per day.					
					·Directorof Nursing or desig	nee	
	Lithium is used	to prevent or control			will conduct rounds to monitor		
	mania in bipolar	disorder. Nursing 2014			medication administrationto		
	_	, 34th Edition, indicates,			ensure proper doses of liquid		
		onsfatigue, lethargy,			suspension medications are		
					dispensed asprescribed by the	е	
	coma, seizures				physician		
		koutsrenal [kidney]			Modication Base skills		
	toxicitymuscle	e weaknessuse with			 Medication Pass skills validation willbe conducted or 		
	caution in debili	tated patientsOverdose			Licensed Nurses upon hire	ı	
		symptoms] diarrhea,			Licensed Hurses apon file		

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ENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155241	B. WIN			10/15/	/2014
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIER	t .			THOMPSON RD		
FOREST	CREEK VILLAGE			INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DECLIDED IN AN OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	15	DATE
	vomiting, drows	iness, muscular					
	weakness, lack of	of coordinationblurred					
	· ·	nloss of consciousness,			What measures will be put in		
	*	eral vascular collapse,			place or whatsystemic chang	_	
		x Warning Drug has a			you will make to ensure that		
					the deficient practice does notrecur?		
	narrow therapeu	•			Hotrecul !		
		htly high values can be			·Licensed Nurses will be		
	dangerous"				in-serviced on Medication		
					Administration including prepa	ring	
	On 10/8/14 at 11	:54 a.m., Licensed			correct doses of liquid		
	Practical Nurse ((LPN) #7 was observed			suspensions by 11/3/14		
	pouring lithium	suspension into a			Madiantian Dana shills		
	medication cup.	The medication cup was			·Medication Pass skills validation to beconducted on		
	-	narked in milliliters,			Licensed Nurses by Director of	of	
		l's, 5 ml's, 7.5 ml's, 10			Nursing or designee	•	
		ml's. There were no					
					·Directorof Nursing or design	nee	
	1	indicated 2.1 ml's, the			will conduct rounds to monitor		
		n Resident #130 was			medication administrationto		
	_	eive. LPN #7 was			ensure proper doses of liquid suspension medications are		
	observed pouring	g the lithium into the			dispensed asprescribed by the	 د	
	medication cup,	then pouring some of the			physician	,	
	medication back	into the bottle, then			' '		
	repeating the ste	ps several times. LPN			·Medication Pass skills		
	#7 indicated at the	hat time, the lithium was			validation willbe conducted on		
		d out with a syringe so			Licensed Nurses upon hire		
	_	sage could be obtained			How the corrective action(s)		
		but the night nurse had			will be monitoredto ensure the		
		nge and LPN #7 couldn't			deficient practice will not rec		
					i.e., what quality assurance	,	
		ringes to use. LPN #7			programwill be put into place	∍?	
	•	acy usually sent a bulk			Pharmacy Services CQI too	ol	
		ges, but no one had			will be utilized weekly x4, mon		
	reordered them.				x 6, and quarterly thereafter fo		
					one year. Data will be submitted to the COI committee for follow		
	LPN #7 took the	lithium she had poured			to the CQI committeefor follow	I .	

up. If 95% threshold is

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/15/	ETED
	PROVIDER OR SUPPLIER		525 E T	ADDRESS, CITY, STATE, ZIP CODE HOMPSON RD		
FOREST	CREEK VILLAGE		 INDIAN	APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	#38's room and president. An obsin the medication amount of lithium between 2.0 and Unit Manager #6 room. She indic "absolutely" be a withdraw the acc from the bottle of #6 left the room syringes, which ml. markings. Lefthe medication relithium in the medication relithium in the medication of a syringe. On 10/8/14 at 12 #6 indicated syringed when prepared Resident #38. A	con cup into the Resident brepared to give it to the servation of the lithium in cup indicated the m was somewhere 2.3 ml's. At that time, is entered Resident #38's ated LPN #7 should using a syringe to curate dose of 2.1 ml's if lithium. Unit Manager and returned with were delineated with .1 PN #7 then returned to boom, threw away the edication cup, and illithium, as ordered with the sedication cup, and illithium for that time she placed ith the bottle of the		notachieved, an action plan w be developed.	ill	
F000371 SS=E	483.35(i) FOOD PROCURE STORE/PREPARI	:, E/SERVE - SANITARY				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLE	ETED
		155241	B. WIN			10/15/2	2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			THOMPSON RD		
EODEST	CREEK VILLAGE				APOLIS, IN 46227		
FUNEST	CREEK VILLAGE			INDIAN	AFOLIS, IN 40221		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The facility must -						
		rom sources approved or					
	considered satisfactory by Federal, State or						
	local authorities; a						
	under sanitary cor	, distribute and serve food					
	· ·	ration, interview, and	EOO	0371	F371 FOOD PROCURE,		11/03/2014
			1 100	03/1	STORE/PREPARE/SERVE -		11/03/2014
	•	ne facility failed to ensure			SANITARY		
		ents, who ate food			What corrective action(s) wil		
	prepared in the k	citchen, received food			beaccomplished for those		
	prepared, distrib	uted and served under			residents found to have beer	n	
	sanitary condition	ons.			affected by the		
	J				deficientpractice?		
	Findings include:						
	1 mamgs merade				·All residents will be served		
	1 0 10/6/14 0	10.00			according to proper food hand	ling	
		om 12:30 p.m. to 12:45			procedures including hand		
	p.m., food service	ce was observed in the			washing and glove use		
	Moving Forward	d dining room. Dietary			·All dietary employees will ha	ave	
	Cook #1 was ob	served preparing each			hair properly restrained	avo	
	resident's plate f	rom a steam table cart.			propony roomanica		
	_	hands and donned			How will you identify		
	gloves. Dietary				otherresidents having the		
					potential to be affected by th	е	
		She opened the bread			same deficient practiceand		
	U -	o slices of bread with her			what corrective action will be	•	
	gloved hands and	d placed the bread on a			taken?		
	plate. Dietary C	ook #1 continued by			·All residents have the poter	ntial	
	picking up a sco	op with her gloved hand			to be affected by the alleged		
		ving of turkey salad on			deficient practice		
	•	d. She then picked up			·Dietarystaff will be in-servic	ed	
		f bread with her gloved			on Infection Control, Use of	eu	
		· ·			Gloves, Hand Washing, Dietary	v	
	_	the bread on top of the			Personal Hygiene and Food	´	
	turkey salad.				Handling policies by the		
					Registered Dietician or design	ee	
	Dietary Cook #1	then picked up the			by 11/03/2014		
	cheese puff scoo	op with the her gloved					
	1		ı				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIC	00	COMPL	ETED
		155241	A. BUIL B. WING			10/15/	2014
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			THOMPSON RD		
FODEST	CREEK VILLAGE				IAPOLIS, IN 46227		
	- CINELIN VILLAGE			INDIAN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	cheese puffs on the plate			Registered Dietitian or		
	next to the turke	y salad sandwich. She			designeewill monitor kitchen processes to ensure proper ha	and	
	continued to pic	k up a bowl and the soup			washing, glove use,	anu	
	scoop and pour s	soup into the bowl. She			hairrestraints, and food handli	na	
	placed these plat	tes on the tray in front of			follows protocol		
	her.						
	nor.				What measures will be put ir	nto	
	Distant Casle #1	Alexander CCI and Alexander			placeor what systemic chang	_	
		then shuffled through			you will make to ensure that		
		of paper with the same			the deficient practicedoes no	ot	
	gloved hands.				recur?	امما	
					Dietarystaff will be in-service on Infection Control, Use of	eu	
	Dietary Cook #1	then picked up two			Gloves, Hand Washing, Dietar	v	
	more slices of bi	read and placed them on			Personal Hygiene and Food	,	
	another plate wit	th the same gloved			Handling policies by the		
	_	inued by picking up the			Registered Dietician or design	iee	
		d placed a scoop of			by 11/03/2014		
		one of the slices of bread.					
					Registered Dietitian or		
		ne gloved hand and			designeewill monitor kitchen processes during each meal to	_	
		y salad around on the			ensure proper hand	١	
	_	She then picked up the			washing,glove use, hair		
	other slice of bre	ead with her same gloved			restraints, and food handling		
	hand and put it o	on top of the scoop of			follows protocol using audit to	ol	
	turkey salad.						
	Dietary Cook #1	continued preparing			How the corrective action(s)		
	1	r the residents with the			will bemonitored to ensure the		
	1 ^				deficient practice will not rec	ur,	
	~	nds. She was not			i.e., what qualityassurance program will be put into place		
		any form of utensil to			A Kitchen	. c :	
		hrough the observation			Sanitation/Environmental Rev	iew	
	*	Cook #1 was not			tool will be utilized weekly X 4		
	observed to rem	ove the original set of			weeks, monthly x 6 months, a	nd	
	gloves and wash	her hands, until after 11			quarterly thereafter for one ye	ar	
	(9 residents and	2 family members) plates			with results reported to the	,	
	`	epared and served.			Continuous Quality Improvem Committee overseen by the	ent	
	l L	1	1		r Commuee overseen by the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	ILDING	00	COMPL	ETED
		155241	A. BUI B. WIN			10/15/	2014
			B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	R			THOMPSON RD		
EODEST	CREEK VILLAGE				APOLIS, IN 46227		
				INDIAN	AFOLIS, IN 40221		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Executive Director		
	On 10/6/14 at 1:	00 p.m., the Dietary			In addition of the annitation		
	Manager indicat	ted Dietary Cook #1			In addition, a full sanitation audit will be conducted by RD		
	_	d a different utensil for			Consultant monthly		
		she was serving, this			Consultant monthly		
		•			·If 95% threshold is not		
	_	ongs to handle the bread			achieved on the		
		ary cook should not have			Sanitation/Environmental Revi	iew	
	used her gloved	hands to pick up the			tool, an action plan will be		
	bread slices.				developed to ensure complian	ce	
	On 10/9/14 at 2:	30 p.m., the Dietary					
		ed the Use of Gloves					
		/2011, and indicated the					
		one currently being used					
		The policy indicated, "					
		st like hands; they get					
	soiled. Anytime	e a contaminated surface					
	is touched, glove	es must be changed and					
	hands washed	C					
	On 10/0/14 at 2:	30 p.m., the Dietary					
	U 1	ed the Food Handling					
	I -	/2014, and indicated the					
	policy was the o	ne currently being used					
	by the facility.	The policy indicated, "					
		ees will clean their					
		sed portions of their arms:					
	^	ng soiled surfaces,					
	· ·	_					
	equipment or uto	ensus,					
	2. During the se	rvice of noon meal on					
	10/10/14 at 11:0	0 a.m., the following					
	were observed:						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 10/15/	ETED
	PROVIDER OR SUPPLIER			525 E T	DDRESS, CITY, STATE, ZIP CODE HOMPSON RD APOLIS, IN 46227	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	have facial hair,	#10 was observed to a beard and mustache, preparing and serving					
	prepare and servi hair net covering hair, exposing the On 10/10/14 at 1 policy provided facility's current Communities Disoriginal date of Cemployees will hygiene to preve contamination Wear a clean hat restraint. Dietar	maintain good personal					
	Manager on 10/1 indicated the star policies are gone and staff receive updates through employment. State the hair cover to and/or facial hair beard) and be we preparation areas						

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00 	COM	PLETED
		155241	B. WING			5/2014
	PROVIDER OR SUPPLIER		525 E T	ADDRESS, CITY, STATE, ZIP CO	ODE	
FOREST	CREEK VILLAGE		INDIAN	APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	utensils.					
	3.1-21(i)(3)					
F000431 SS=E	& BIOLOGICALS The facility must e services of a licen- establishes a syste and disposition of sufficient detail to reconciliation; and records are in orde all controlled drugs	s, LABEL/STORE DRUGS mploy or obtain the sed pharmacist who em of records of receipt all controlled drugs in enable an accurate determines that drug er and that an account of s is maintained and				
	must be labeled in accepted profession include the appropriate the appropriate in the appropriate for the second control of the seco	cals used in the facility accordance with currently onal principles, and oriate accessory and tions, and the expiration				
	the facility must sto biologicals in locked proper temperatur	n State and Federal laws, ore all drugs and ed compartments under e controls, and permit only nel to have access to the				
	permanently affixe storage of controlle	rovide separately locked, ed compartments for ed drugs listed in Comprehensive Drug				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		155241	B. WIN			10/15/	2014
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	R			THOMPSON RD		
FOREST	CREEK VILLAGE				IAPOLIS, IN 46227		
				INDIAN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		and Control Act of 1976					
		ubject to abuse, except					
		ises single unit package					
		ystems in which the minimal and a missing					
	dose can be readi						
		ration, interview, and	F00	0431	F431 DRUG RECORDS,		11/03/2014
			100	0431	LABEL/STORE DRUGS		11/03/2014
		ne facility failed to store			ANDBIOLOGICALS		
		safe and sanitary manner					
		tion carts reviewed for			The facility mustemploy or obt	ain	
	medication stora	ige. (West Back			the services of a licensed		
	Medication Cart	#1, West Medication			pharmacist who establishes a		
	Cart #2, East Me	edication Cart A, East			systemof records of receipt an		
		B, and Augusta's			disposition of all controlled dru in sufficientdetail to enable an		
	Cottage Medicat	•			accurate reconciliation; and		
	Collage Medical	non Cart)			determines that drug recordsa	re	
					in order and that an account o		
	Findings include	2.			controlled drugs is maintained		
					andperiodically reconciled.		
	1. During a review	ew of the West Back			Drugs and biologicalused in th	ie	
	Medication Cart	#1 on 10/15/14 at 10:45			facility must be labeled in		
	a.m., the medica	tion cart was found to			accordance with currently		
		of dust and debris in each			acceptedprofessional principle	es,	
	drawer, as well a				and include the appropriate accessory and		
	•	•			cautionaryinstructions, and the	<u> </u>	
	medications. Th				expiration date when applicab		
		ed the drawers making			In accordance withState and		
	_	lacement of the packages			Federal laws, the facility must		
	difficult. The bo	ottom drawer had a white			store all drugs and biological		
	and brown subst	ance splashed on the			inlocked compartments under		
	sides and bottom	n of the drawer. Licensed			proper temperature controls, a		
		(LPN) #7 indicated the			permit onlyauthorized personn	nel	
		ed by the night nurses			to have access to the keys.		
					The facility mustprovide separately locked, permanentl	v	
	according to the	schedule.			affixed compartments for stora		
					ofcontrolled drugs listed in	-5~	
		Nursing Services (DNS)			Schedule II of the Comprehen	sive	
	and Unit Manag	er (UM) #6 were present			Drug AbusePrevention and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		155241	B. WIN			10/15/2014	
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹					
FODEST					THOMPSON RD		
FUREST	CREEK VILLAGE			INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETI	ION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	during the review	w of the medication cart.			Control Act of 1976 and other		
	The DNS indica	ted the loose pills were			drugs subject to abuse,		
		nd totaled 70 whole pills,			exceptwhen the facility uses		
		•			single unit package drug		
	_	1 19 and 1/2 half pills.			distribution systems in whichth		
		s were various sizes,			quantity stored is minimal and missing dose can be readily	a	
	shapes, and colo	ors.			detected.		
					What corrective action(s) wil		
	2. During a review	ew of the West			be accomplishedfor those	·	
	_	:#2 on 10/15/14 at 11:05			residents found to have been	ı	
		ation cart was found to			affected by the deficient		
					practice?		
	have a build up of dust and debris as well as multiple loose medications. LPN #8				· All medication carts have be	een	
					cleaned and overstocked		
	indicated the me	edications were			medications have been remov	ed	
	unidentifiable ar	nd totaled 27 and 1/2					
	pills, 4 of which	were capsules. The			How will you identify other		
	_	re various sizes, shapes,			residents havingthe potentia		
	and colors.	, arreas sizes, shapes,			to be affected by the same		
	and colors.				deficient practice and what		
		2.4			correctiveaction will be taken		
	3. During a revi				·All medication carts have be		
	Medication Cart	:#A on 10/15/14 at 11:15			cleaned by Nurse Managers a overstocked medications have		
	a.m., the medica	tion cart had a build up			been removed		
	of dust and debr	is and a dried brown					
		bottom drawer, as well			·Licensed Nurses will be		
		tions. UM #3 indicated			in-serviced on proper medicat	on	
					storage by 11/3/14		
		were unidentifiable and					
	totaled 4 and 2 1	-			·Daily cart audits will be don	·	
	medications wer	re various sizes, shapes,			Nurse Managers to ensure ca		
	and colors. UM	#3 indicated the carts			are free from debris, organized	d,	
	were cleaned by	the night nurses and			and no loose pills		
	<u> </u>	on a weekly basis by the			Licensed Nurses will wiss		
	UM.	in a weeking outlit by the			·Licensed Nurses will wipe down carts after each shift		
	UIVI.				down carts after each stillt		
	1				Pharmacy consultant will au	ıdit	
	1	ew of East Medication			medication carts monthly for		
	Cart #B on 10/1	5/14 at 11:20 a.m., the			proper storage		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIC	00	COMPLETED	
		155241	A. BUII B. WIN			10/15/2014	
		<u> </u>	B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		l	THOMPSON RD		
FODEST	CREEK VILLAGE				IAPOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		had 4 loose pills in the					
	drawers. LPN #	8 indicated the pills			M/bet messerines will be mut im	4.	
	could not be identified.				What measures will be put in place or whatsystemic change	l l	
					you will make to ensure that	Jes	
	5. During a revie	ew of the Augusta's			the deficient practice does		
	_	tion Cart on 10/15/14 at			notrecur?		
	_	eart had a build up of dust			·All medication carts have be	een	
	· ·	•			cleaned and overstocked		
	-	ell as loose medications.			medications have been remov	ed	
		d the medications were					
		nd totaled 9 and 3 1/2			·Licensed Nurses will be		
	pills, 3 of which were capsules. UM #3 indicated the nurses were responsible for maintaining the cleanliness of the carts.				in-serviced on proper medicat storage by 11/3/14	on	
					Storage by 11/3/14		
					·Daily cart audits will be don	e by	
					Nurse Managers to ensure ca		
	On 10/15/14 at 1	1:00 a.m., UN #6			are free from debris, organized		
		ing schedule for the			and no loose pills		
	•	n carts. The schedule					
		l was cleaned on			·Licensed Nurses will wipe		
					down carts after each shift		
	_	art #2 was cleaned on			·Pharmacy consultant will a	dit	
	Wednesdays.				medication carts monthly for		
					proper storage		
	On 10/15/14 at 1	1:45 a.m., UM #3					
	indicated a writt	en schedule was not			How the corrective action(s)		
	available for the	cleaning of the East			will be monitoredto ensure the		
		igusta's Cottage Cart.			deficient practice will not rec	ur,	
		.8			i.e., what quality		
	On 10/6/14 at 11	:09 a.m., the DNS			assuranceprogram will be pu into place?	١	
		•			·Medication Storage CQI too	.	
		edication Storage			will be utilized weeklyx 4, mon	l l	
	_	olicy dated 2/2014 and			x 6, and quarterly thereafter fo		
	•	licy was currently used			one year. Data will be submitt		
	1 -	Γhe policy indicated,			to the CQI committeefor follow		
	" Purpose To en	sure drugs and			up. If 95% threshold is		
	biologicals are s	tored in a safe and secure			notachieved, an action plan w	II	
	manner in accord				be developed.		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	LETED
		155241	B. WIN			10/15	/2014
NAME OF F	PROVIDER OR SUPPLIE	R.	-		ADDRESS, CITY, STATE, ZIP CODE		
					HOMPSON RD		
FOREST	CREEK VILLAGE			INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	manufacture's re	ecommendations and					
	State and Federa	al laws, rules, and					
	regulations3.1	. Medication cartsmust					
	_	size to permit storing					
		rowding3.2. The					
		aration area is to be					
		ursing staff in a clean and					
	organized mann						
	organized mann	C1					
	2125()						
	3.1-25(m)						

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